Minutes

DCF Learning Center Conference Room, Topeka KS
June 26, 2013 1:30-3:30pm

Those attending in person:
Kim Brown, Ren Mullinix, Effie Swanson, Cindy Stortz, Cheryl Rathbun, Greg Hennen, Sandra Dixon, Jeremy Whitt, Secretary Shawn Sullivan, Greg Wintle, Bala Vanukuru, Mike Larkin

Those attending by telephone: Larry Martin, Jacque Clifton, Ric Dalke, Jerry Delashaw, Scott Hines, Lora Key

Those Absent: Lori Feldkamp, Jennie Henault, Dale Stiffler, Elizabeth Maxwell, Lori Lowrey, Barbara Timberlake

Opening Comments:
Kim Brown, KDADS
Kim welcomed the members and introduced Secretary Shawn Sullivan who went over the Intellectual and Developmentally Disabled (IDD) Waiver Pilot Program.

IDD Pilot Program:
Sec. Shawn Sullivan

Sec. Sullivan stated the reasons the Legislature had decided to place IDD Waiver Pilot program in KanCare were:

1. To allow for better care coordination
2. Because there are more services available to the DD population, it allows more flexibility unlike the old fee for service (FFS) system previously being used.
3. By paying improved outcomes we should see better results.

At this point, Sec. Sullivan stated there are more than 500 beneficiaries in the pilot program and around 25 providers. He stated the Plan of Care (POC) process was coordinated through an Advisory Council in an attempt to help things to move smoothly during transition.

Sec. Sullivan then went over more of the handouts with explanations for clarification purposes. Please see handouts. Once he had finished his presentation, Sec. Sullivan introduced Greg Wintle from KDADS and opened the floor to questions.

- Q: Regarding case managers and targeted case manager's being available in January, how will the TCM's units be authorized?
  A: Greg stated that was a great question. For now there is a process in place for additional units. Currently, the State is reviewing and authorizing additional units. This may need to be discussed further at a later date.

- Q: Regarding streamlining residential units. Is there any possibility to re-explore or pilot this? Are you able to put forth any recommendations regarding these? HCBS-FE funding has been a challenge regarding markets, or lack thereof. He went on to state that T2030-T2033 HIPPA inactive codes, that if they were activated, would open conversation for residential services.
  A: Sec. Sullivan clarified that he was asking for an increase in the HCBS assisted living per diem # for units. Sec. Sullivan then gave a back ground of how that worked for those that were not familiar with these services.

Q: Jeremy went on to state there are no activated HIPPA codes or other codes they need to appropriately process their reimbursement in the State of Kansas that will even allow for these types of discussions at this time.
A: Sec. Sullivan stated that KDADS would have an internal conversation regarding this, and then get together with the MCO's and discuss it further. He thanked Jeremy for bringing this to his attention.

- Q: Jeremy then stated that this would be very helpful as the administrative costs to them had tripled.
  A: Thank you

- Suggestion: Another member suggested working with residential providers to provide a one year continuity of care payment guarantee as they are working through the contracting process with MCOs so as not to disrupt the individual's home.
  A: Sec. Sullivan stated that he was not certain the continuity of care period would last for one year, but there was a budget proviso passed by the Legislature that would put into law the protections of continuity to care. KDADS will go back and look at the length specified in the proviso and have it be a point of discussion.

- Q: There have been several discussions regarding the value added services and if they are going to remain as part of the pilot. Has there been any final determination on how FMS providers specifically handle those value added services by the MCO's?
  A: Ren responded that this was something they had scheduled to meet about with the Advisory Group. The answer is still under discussion.

There were no further questions and Kim thanked Secretary Sullivan for coming to update the group on this program.

KanCare Website Tour:
Ren Mullinix, KDHE

Ren began by asking if there was anything that could be improved upon or anything that could be made more readily available on the KanCare website. He stated that two of his favorite sections were the "Policies and Reports" and the "About Us" sections down at the bottom of the page or on top on the banner. A lot of very useful information can be found in those two places.

Under the "About Us" section, under the "news" section you can find the KanCare Advisor, which is a monthly newsletter regarding changes and highlights for KanCare. If you would like to be on the listing and are not currently, Ren recommended individuals sign up for this to keep up to date on all the changes as they come along.

Ren then asked how going into the individual MCO websites has worked for most people. Some concerns were how the items are labeled such as title names being inconsistent to things that users may be used to hearing or using.

There are several different numbers you can call for assistance. It was stated that this section may need updated and if any workgroup member notice things that are out of date, please email Ren and let him know. rmullinix@kdheks.gov.

Effie Swanson then helped lead group members to where they could find MCO and subcontractor information. Ren indicated that he and Effie went through the website recently and found several things that need to be updated and will be working on those things in the next few weeks.

- Q: So how does this work, do you all design your own websites or do you have someone else to do that?

A: Ren answered that KDHE has a webmaster that receives the information for website and actually places that information onto the appropriate web page. The individual plans have their own web sites.

Effie added that the State's typical process would be when a frequently asked question is noticed, to put together some information about it, gather similar information from the MCO's and place it on the website either via bulletins or just a blurb on the webpage.

Kim added that another example of what goes onto the website is that they recently had some HCBS forums which were documented on the website. There is draft documentation being prepared currently, and the State is waiting on input from the public, so it may be a good idea to check the website frequently to keep up with changes.

- Q: I did notice there are a couple of hyperlinks on the Amerigroup webpage that do not open to any forms as the others do. This is on the Pharmacy page and the forms would be very useful if we could access them.
  A: We will be contacting Amerigroup and letting them know that this will need to be fixed. Ren indicated that was a great example of the type of things that are useful for him to know so they can get repaired and available for everyone to use.

Kim indicated that if there are any changes or things you would like to see on the website, please either notify Ren or anyone else from the State on this workgroup and we will let someone know that will be able to do some updating. The website is designed to be a source of information and reference materials for the public.

- Q: : Another issue was brought to light regarding a form on the United Healthcare website that is so small it is very difficult to read or complete.
  A: That will be taken back to United for repair also.

Health Homes Project:
Effie Swanson, KDHE

Effie then began her presentation by showing everyone how to find the information regarding Health Homes on the KanCare website. Effie indicated that most of the information is generalized at this point in time, but it will get more detailed the closer we get to our implementation date.

Effie then began with indicating what Health Homes (HHs) are and how they came to be. Effie indicated she wanted to make sure to clarify that a Health Home is not a building, it's not a facility, but rather it is more of a system of care coordination and integration of services and supports for people with complex chronic conditions. Health homes are a Medicaid State plan option, so the State will use the State Plan Amendment process to define the health home program. Effie went on to explain that rather than taking away services, HHs actually add six services to the providers' arsenal in providing the intense treatment the conditions will require. The six services are specified by CMS, but the State defines what those services mean. A draft of those definitions will be presented at a health homes forum on the 23rd of July. If you happen to go out on the website and have some feedback on those forms, please feel free to email Effie or Becky Ross at healthhomes@kdheks.gov.
For our purposes, the State of Kansas is defining a Health Homes Model to consist of:

1. The consumers' MCO plan (Lead entity); and
2. Another community provider (HH Partner)
   (SIL, CMHC, PCP, FQHC, SUDP, etc)

Very specific Provider Qualifications will be spelled out in the State Plan Amendment. Kansas is the first state to use this model. No other state has implemented their entire HH population in a fully capitated managed care environment. Effie noted that the State is working with CMS pretty closely, as things are looking a little different for Kansas than for some of the other states using the Health Home model.

Effie also noted that the State has to keep in mind the differences in our state as compared to others also. For example, we have a lot of rural areas that perhaps New York would not have, which will make our model different also. We have to keep in mind all the differences and try to embrace and include all of those in the model.

The first group that the State is going to enroll in HH's is the Severely Mentally Ill (SMI) population. The State chose to begin with those because we have a good Community Mental Health Center (CMHC) system already in place, compared to the diabetes population, for example, which uses a variety of different providers and is a much larger population. CMHC's may not be the only providers that are qualified to provide the needed services, but they are an example of the types of providers who could become a HH partner. The State believes that if we begin with a smaller population, we can learn from that experience and will be better suited to bring others on board.

- Q: When you say "Services provided by the MCO's " are you saying subcontracted services?
  A: No necessarily, it could be the care coordinators that are employed by the MCOs who provide some of the care coordination and care management services.
  Q: So you're not actually talking services, you are talking coordination of those services?
  A: Many of the health homes services are related to care coordination. Providers cannot bill for care coordination now, but in the HH's program it is an actual billable service. Kim indicated it was kind of a service today as we have Case Management that is very similar to that. Effie indicated the care coordination will be an actual billable service in HHs.

A workgroup member made the comment that folks really needed to be signing up for the forum coming up on the 23rd of July. She stated that she did and gave her reasoning for doing so, indicating she had been contacted by an MCO regarding getting accreditation for the population her company serves. She stated she just needed a little more clarification regarding what this consisted of. Effie indicated she should get that information at the forum.

Effie indicated the main key for making these HH's work is communication. Communication between the MCO and HH Partner or any other providers actively engaged with working with the consumer either in person or by phone. Communication should be coordinated between all providers and the consumer for clarification of services needed and provided.

- Q: So is the Per Member Per Month (PMPM) all inclusive? Or is there a PMPM for HH services and also a pot of money for those other services not included in the HH?
  A: Effie indicated what they had envisioned is that the MCO's currently get PMPM for each of their members with all the different rate cells. The PMPM the MCO gets for the original services will not change. We envision an additional PMPM that comes in on top of that for the additional services that they are now expected to provide.

- Q: So it's not true capitation? It's not one pot of money no matter what?
- A: Right. Its two different capitated payments. The first capitated payment is for all their KanCare services that were negotiated between the MCO's and the State. That is still truly capitated. The MCOs are still absolutely at risk for everything they were before, but now there are these six additional services. The risk is shared between

the HH Partner and the MCO. The HH Partner is not responsible for hospitalization services or anything like that, they are just responsible for their portion of those six HH services.

- Q: So the Partner is not responsible for regular doctor visits, dental visits and all that?
- A: No, the Partner is just responsible for those core six services. The MCO is still responsible for the other services just like they were previously. The partner can still provide all of the services to consumers that they previously provided, but the additional health homes payment will be tied to their contracted portion of the six health homes services.

Regarding the Project Structure:

- The State has people from KDHE, KDADS, and our technical assistance partners (CMS).
- There is also a Project Team involved, consisting of State staff, university and actuary partners and MCO representatives. This team has been working on researching what the conditions may be that are services in the future implementations.
- The State has also convened a Health Homes Focus Group, which has grown into a very large group, composed of different provider organizations from across the state, KU contractors, a couple of consumer advocates, foundation representatives and a large array of stakeholders. This group is used for brainstorming ideas; and reviewing draft documents for input. They have been in place for more than a year and usually meet bimonthly.
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The State is also required to consult with the Substance Abuse and Mental Health Services Administration (SAHMHSA). The State will bring our proposed model to them for their input as well as the Kansas tribal groups.

Effie indicated the next step would be submitting the State Plan Amendments (SPA) for federal approval. The above information will be submitted in October or November, so CMS can review it before the January 1, 2014 implementation date. Once the SPA is approved by CMS, the State will claim 90% federal match for all those six HH services for individuals in the HH for two years, and then after that it will be regular match. The HH services won't stop, it will just be the State paying a larger portion of those services after the initial enhanced match is over.

- Q: Given the time line that you just described, a submission of a plan amendment in November, how are the providers going to be prepared and know they are qualified if the plan hasn't been approved yet and January 1 they need to be equipped, have their staff trained and have an infrastructure in place to deliver those six core services?
  A: Just because we don't submit it to CMS until later in the year does not mean providers would not begin getting engaged now. That's part of why the forum is in place, and the focus group is in place. The State will present some draft provider qualifications at the forum in a few weeks and providers will have a chance to provide input on them. One of the things the State may do, is a survey of providers who attend and ask them which of the qualification they believe they could do right now? The state will also ask providers, which of these things do you feel you could do by January 1st given the appropriate resources, and which of these things are just not reasonable?

  A number of different efforts are also in place to get providers up to speed and get them ready to go. Becky reminded the Focus Group on Friday that part of their responsibility as members is to take the information they obtain from the meetings back to their organizations, to their provider affiliations or associations and share it with them. For example, since Greg is with the CMHC's, he needs to make sure his entire association and all the agencies across the state get that information and any questions are forwarded to the State. Because

geographically Kansas is a big state, that is part of the membership responsibilities on these committees, teams and workshops.

Effie asked if there were any other questions, to which there were none at this time.

Closing Comments:
Kim Brown, KDADS

Kim thanked Effie for her presentation and then asked anyone if had any ideas of things that may need to be on their future agenda's. The workgroup's next meeting is scheduled for September 25th from 10am-12pm at the DCF learning Center in Room C.

Kim reminded members of the charter focus. Kim stated that if there was any provider educational material that may need to be reviewed, that may be brought to this group. She also noted that members should ensure that their particular groups' perspective is provided and the MCO's will bring information about their provider committees that they have up and going or are getting ready to have up and going.
Kim asked if anyone had anything they would like to hear about in September. The following were suggested topics from the workgroup members:

- Would you explain what the MCO provider committees are for?
- Consider a survey to HCBS consumers who are already in KanCare to determine their level of satisfaction with the care coordination. The survey could include questions about how the program is going over all, and where the enhanced care coordination will come from.
- Provider discussions regarding prior authorizations. MCO silo issues.
- Utilization data by levels of care compared to when Value Options was managing substance abuse treatment.

Kim adjourned the meeting at 3:30pm.

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